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ABSTRACT

This study specifically explored the relationships among childhood trauma, long-term psychological consequences, beliefs about family violence, and gender role stereotypes in Asian and Asian American women. A prediction was made that childhood physical violence and witnessing family violence would create long-term negative symptoms; higher levels of acceptance of violence; more patriarchal gender role stereotypes; and endorsement of male power roles and rejection of female power roles. Women (N=52) from the University of Michigan participated in the study. The results suggest that childhood physical abuse and witnessing family violence had a long-term debilitating impact on the women. A history of abuse was also associated with trauma symptoms, depression, psychosomatic symptoms, and anxiety. It suggests that the traditional patriarchal family system within Asian homes, exposure to violence, and acceptance of child physical abuse and spousal violence may be critical risk factors for the perpetuation of the cycle of violence across generations. Counselors need to develop alternate risk models of family violence and interventions to better target these families. (Contains 16 references.) (Author/JDM)

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Family Violence: Psychological Consequences and Beliefs in Asian and Asian-American Women

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Summary

Background and Significance: The present study is a preliminary investigation of exposure to violence (physical abuse and witnessing family violence), mental health functioning, gender role stereotypes, and attitudes toward family violence among Asian and Asian-American women in the United States. Because researchers tend to focus on Caucasian samples, there is a paucity of research on cross-cultural issues related to child abuse and family violence. Furthermore, studies on Asian women and trauma frequently use small clinical or refugee samples and lack control groups, which limits our understanding of violence within Asian homes.

Although sexual and physical abuse have been documented among Asians (Haffejee, 1991; Ima & Hohm, 1991; Mckelvey & Webb, 1995), consequences of family violence among this population remain largely unknown. One study by Rao, DiClemente, and Ponton, (1992) supported cross-cultural differences in high-risk sexual behaviors, suicidality, and anger across Asian, African-American, Caucasian, and Latina victims of sexual abuse. However, it remains unclear if Asians exposed to violence exhibit symptoms of depression, trauma, and psychosomatic problems as previously documented for Caucasian samples (Briere & Runtz, 1988; Browne & Finkelhor, 1986; Russell, 1991). Cultural norms suggest that anxiety and psychosomatic symptoms may be more prevalent than depressive and trauma symptoms in this population.

The relationships among exposure to violence, beliefs about violence and parenting, and gender-roles stereotypes also remains largely unexplored among different ethnic groups. For instance, Hong & Hong (1991) showed that Chinese judged parental conduct less harshly and seemed to be less critical of the use of physical force by parents compared to Hispanics and Caucasians. It is possible that traditional gender roles and patriarchy within Asian families may increase the risk for and acceptance of family violence. That is, the dynamics of family violence, the acceptance of violence, and psychological outcomes of violence may be unique to one's culture.

Thus, the present study explored the relationships among childhood trauma (physical abuse and witnessing family violence), long-term psychological consequences, beliefs about family violence, and gender role stereotypes in Asian and Asian-American women. We hypothesized that:

1. Childhood physical violence and witnessing family violence would predict long-term negative symptoms of trauma, depression, anxiety, and psychosomatic problems.
2. Experiencing physical violence and witnessing family violence would predict higher levels of acceptance of violence as an appropriate means of physical discipline and violence as a parental/spousal right and privilege.
3. Witnessing family violence would predict more patriarchal gender role stereotypes; i.e., higher male power oriented gender roles and lower female power oriented gender roles in the family.
4. Endorsement of male power gender roles and rejection of female power gender role stereotypes would predict higher acceptance levels of child and spousal violence as a parental right and privilege.

Sample and Methods

The present data is taken from a portion of a larger and ongoing study. Fifty-two women from the University of Michigan participated in the present study. A convenient and non-clinical sample was chosen so that the results can be generalizable to other educated and English-speaking Asian-American groups.

Sample: Fifty-two Asian and Asian-American women volunteered for a study on their experiences of violence and mental health functioning at the University of Michigan. The age range of the women was 18 to 40 years (χ = 25, SD = 4.8). Self-identified ethnic groups based on country of origin included South Asian-American (42.3%), South Asian (13.5 %), East Asian-

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American (21.2%), East Asian (13.5%), Middle Eastern-American (3.8%), Middle Eastern (3.8%), and Bi-Racial (1.9%). Regarding current marital status, 80.8% of the respondents were single, 15.4% were married, and 3.8% were separated/ divorced. To determine income levels of the participants, we used Stevens and Featherman's (1981) revised socioeconomic index of occupational and income status. The average annual income for the sample was $79,000. The majority of the participants came from middle to upper class families.

Recruitment. All participants were recruited from the University of Michigan. Participants were contacted via minority group email addresses on campus. Prospective participants were sent an email that briefly described the study and asked interested participants to contact the primary investigator (PI). The PI then sent potential participants a standardized email explaining that the purpose of the study was to assess experiences of stress and trauma in childhood. Participants were assured of their anonymity. Participants were informed that the study required them to fill out a battery of self-report questionnaires that would take no more than three hours to complete. If the participants agreed, they were mailed the survey and a consent form. Participants took the survey home to maintain anonymity and mailed the survey back to the PI within one week. 72 questionnaires were distributed and 52 questionnaires were returned, indicating a high return rate (72%).

Measures: Participants completed a battery of standardized self-report measures on exposure to family violence, beliefs about violence, gender role stereotypes, and mental health functioning.

Childhood physical violence: Eight items from Finkelhor's (1979) questionnaire pertaining to respondents' experiences of physical violence by their caretakers were used. Subjects were asked to list the number of violent acts they had experienced and the number of persons who physically hit them before the age of sixteen. The behaviors measured ranged from mild violence (slapped, pulled hair) to severe physical violence (burned with cigarette, caused a bone to break). The internal consistency of this scale was $\alpha = .72$

Beliefs about physical discipline: A Likert scale was developed to measure participants' beliefs about physical violence as an acceptable form of punishment for children. For each behavior listed, participants responded on a scale ranging from 1 = strongly disagree to 5 = strongly agree.

Witnessing family violence: The Parental Violence Scale (PVS) (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) from the Revised Conflict Tactics Scale (CTS2) was used to assess the frequency of physical violence participants witnessed between their family members before the age of sixteen. We used 3 scales of the PVS with internal consistencies of: physical assault ($\alpha = .86$), psychological aggression ($\alpha = .79$), and injury ($\alpha = .95$). Participants responded by listing the number of times that they had witnessed each behavior per year. The frequency reported for each item was added together for each participant to achieve a total PVS score. The present PVS scale had an internal consistency of $\alpha = .83$.

Beck Depression Inventory (BDI): Depression was measured by the short form of the BDI (Beck, 1972). The short form of the BDI consists of 13 questions pertaining to depressive symptoms experienced in the last 2 weeks and has a high reliability ($\alpha = .87$). The numbers assigned to each response was added together for each participant to achieve a total BDI score. The present study using the short form of the BDI had an internal consistency of $\alpha = .82$

The Trauma Symptom Checklist (TSC): The TSC (Briere & Runtz, 1989) consists of 40 questions pertaining to trauma symptoms experienced in the last two weeks based on a four point scale ranging from 0 = never to 3 = very often. The TSC inquires about the frequency of items such as headaches, flashbacks, spacing out, fear of men, and feelings of guilt. The internal consistency of the scale is reported to be $\alpha = .89$. The score reported for each response was added together for each participant to achieve a total TSC score. The present TSC scale had an internal consistency of $\alpha = .92$

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Assessment of gender role stereotypes in families: Graham-Bermann and Brescoll (1998) developed the Gender, Power and Violence scale to assess Male Power, Female Power, Violence Privilege, and Family Autonomy. The GPV scale consists of 41 questions used to assess stereotyped beliefs. The four factors of this scale include: 1) domination, (e.g., "the man is king of the castle…"); items also have the reverse to attribute power to mothers/ wives as well; 2) violence as parents' prerogative, (e.g., "fathers have a right to hit their kids whenever they want to"); 3) superiority of the traditional family form, (e.g., "it is wrong when there is no man in the family"); and 4) the right to privacy and autonomy from outside institutions, (e.g., "the police cannot tell fathers what to do when they are inside their own home"). The GVP scale consists of a Likert scale ranging from strongly disagree (1) to strongly agree (4). Responses were added up for each of the four subscales to be used as separate total scores in the analyses. The internal consistency for the entire scale was $\alpha = .95$

The Symptom Checklist – 90 – Revised (SCL –90-R): The SCL –90 –R (Derogatis, 1994) is a 90-item self-report inventory of how much different symptoms caused the participant distress in the past two months. The scale consists of 10 subscales: somatization, obsessive-compulsive behaviors, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism, and global symptoms measured on a Likert scale ranging from not at all (0) to extremely (4). The numbers assigned to each response were added together for each participants to receive a total SCL –90-R score. The present SCL—90-R scale had an internal consistency of $\alpha = .97$. Four subscales were also examined separately as correlates of childhood trauma.

Results

Childhood Physical Abuse and Witnessing Family Violence as Predictors of Long-Term Symptoms: Childhood physical abuse was correlated with witnessing family violence, ($r = .28$, $p < .04$), indicating the co-existence of stressors. Both physical abuse and witnessing family violence were associated with long-term symptoms. Physical abuse was associated with higher levels of overall trauma symptoms ($r = .31$, $p < .04$), symptoms of depression ($r = .40$, $p < .01$) and anxiety ($r = .33$, $p < .02$) on the trauma symptom checklist. Physical abuse was also associated with psychosomatic symptoms ($r = .32$, $p < .03$), depression symptoms ($r = .33$, $p < .02$), and obsessive-compulsive symptoms ($r = .39$, $p < .01$) on the SCL-90-R. Interestingly, witnessing family violence was not correlated to any trauma symptoms or depression, but was associated with higher levels of psychosomatic symptoms ($r = .30$, $p < .05$) and anxiety symptoms ($r = .29$, $p < .05$) on the SCL-90-R. In order to assess which childhood trauma was a more powerful predictor of long-term symptoms as measured by the SCL-90-R, we conducted a multiple linear regression. Results showed that childhood physical abuse was a more powerful predictor of a greater number of overall symptoms $F(2, 37) = 4.49$, $p < .02$, $R^2 = .20$; $\beta = .35$, $p < .03$; psychosomatic symptoms $F(2, 40) = 4.03$, $p < .03$, $R^2 = .17$; $\beta = .26$, $p < .09$; and obsessive compulsive symptoms $F(2, 39) = 4.33$, $p < .02$, $R^2 = .18$; $\beta = .35$, $p < .02$; while witnessing family violence was a more powerful predictor of anxiety symptoms $F(2, 40) = 3.63$, $p < .04$, $R^2 = .15$; $\beta = .28$, $p < .06$.

Exposure to Violence and Beliefs about Violence: Women who had been physically abused had higher acceptance levels of physical violence as an appropriate means of discipline than women who had not experienced physical abuse ($r = .26$, $p < .04$). Witnessing family violence was associated with higher acceptance levels of hitting children as a parental right and privilege ($r = .35$, $p < .01$), by both mothers ($r = .33$, $p < .01$) and fathers ($r = .35$, $p < .01$). Witnessing family violence was also correlated to higher acceptance levels of spousal violence by both mothers ($r = .37$, $p < .01$) and fathers ($r = .36$, $p < .01$). In a multiple linear regression with physical abuse and witnessing family violence as predictors of the belief that parents have a right and privilege to hit

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their child and spouse, only witnessing family violence predicted mothers' right to perpetrate child and spousal abuse F (2, 40) = 3.21, $p < .05$, $R^2 = .14$; $\beta = .30$, $p < .05$, and fathers' right to perpetrate child and spousal abuse F (2, 40) = 3.5, $p < .03$, $R^2 = .15$; $\beta = .34$, $p < .02$. The results indicate that witnessing family violence is a more powerful predictor of acceptance of violence, and that the more violence one is exposed to, the more likely one will accept child and partner violence as a norm.

Exposure to Violence and Gender Role Stereotypes: Witnessing family violence was negatively correlated ($r = -.28$; $p < .03$) with female power gender roles within the family (e.g., the mother owns her children; the mother is queen of the house). That is, the more family violence the participants had been exposed to, the less they endorsed female power roles within the family. A multiple regression with child physical abuse and witnessing family violence as predictors showed that higher levels of witnessing family violence was the only predictor of lower levels of acceptance of female power roles in the home F (2, 39) = 3.30, $p < .05$, $R^2 = .15$; $\beta = -.37$, $p < .02$. This suggests that exposure to domestic violence may be a risk factor in shaping the rejection of female power oriented gender roles within the family.

Gender Role Stereotypes and Beliefs about Violence: Higher levels of gender role male and female power stereotypes were associated with higher acceptance levels of child and spousal violence. Endorsement of female power gender role stereotypes (e.g., the mother owns her children; the mother is queen of the house) was associated with higher levels of acceptance of hitting a child as a mother's right and privilege ($r = .61$, $p < .00$) and hitting her spouse as a right and privilege ($r = .58$, $p < .00$). Endorsement of male power gender role stereotypes (e.g., the father owns his children; the father is king of the house) was also associated with higher acceptance levels of hitting a child as a parental right and privilege ($r = .77$, $p < .00$) and hitting a spouse as a right and privilege ($r = .77$, $p < .00$).

Multiple regressions with male and female power gender role stereotypes as predictors of acceptance of violence indicated that higher male power gender role stereotypes (F (2, 48) = 56.5, $p < .00$, $R^2 = .70$; $\beta = 1.2$, $p < .00$) and lower female power gender role stereotypes ($\beta = -.57$, $p < .00$) predicted higher acceptance levels of fathers' violence against mothers. Interestingly, only higher male power gender role stereotypes predicted higher acceptance levels of mothers' violence against fathers, F (2, 48) = 35.7, $p < 00$, $R^2 = .60$; $\beta = .92$, $p < .00$). Similarly, only higher levels of male power gender role stereotypes predicted higher acceptance levels of both fathers (F (2, 48) = 35.7, $p < .00$, $R^2 = .60$; B = .92, $p < .00$), and mothers (F (2, 48) = 22.15, $p < .00$, $R^2 = .48$; B = .56, $p < .00$) hitting a child as a parental right and privilege. Mothers' power gender roles were insignificant as a predictor of acceptance of child and spousal violence. The results suggest that traditional patriarchal family structures with male power gender role stereotypes may be an important risk factor for the acceptance of family violence.

Conclusion

In sum, the present study suggests that both childhood physical abuse and witnessing family violence have a long-term debilitating impact on Asian and Asian-American women. Childhood physical abuse was associated with trauma symptoms, depression, psychosomatic symptoms, and obsessive compulsive symptoms, while witnessing family violence was associated with anxiety and psychosomatic symptoms. The present study also informs us about intergenerational parenting attitudes and behaviors among Asians and Asian-Americans that could perpetuate family violence. Exposure to family violence predicted rejection of female oriented power gender roles within the family and increased acceptance of spousal and child abuse as a mothers' and fathers' right and privilege. In turn, endorsement of male power gender role stereotypes predicted higher acceptance levels of violence against a spouse and a child by

both fathers and mothers. Thus, the traditional patriarchal family system within Asian homes, exposure to family violence, and the acceptance of child physical abuse and spousal violence may be critical risk factors for the perpetuation of the cycle of violence across generations. Clinicians and researchers need to develop alternate risk models of family violence and interventions to better target these families.

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